

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Swan Health at Wichita Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Grace St Wichita Falls, TX 76301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51721</p> <p>Based on interview and record review the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 2 of 2 residents (Resident #294 and Resident #295) reviewed for advanced directives.</p> <p>1. The facility failed to complete Resident #294's Out-of-Hospital Do Not Resuscitate (OOH DNR) on admission or in a timely manner.</p> <p>2. The facility failed to ensure Resident #295's code status was documented on admission or in a timely manner.</p> <p>These deficient practices could place residents at risk of not having their wishes known, which could affect whether they receive emergency medical treatment.</p> <p>The findings include:</p> <p>1. Record review of Resident #294's electronic face sheet, dated 03/20/2025, revealed a [AGE] year old female who was admitted to the facility on [DATE]. Resident #294 had diagnoses which included; critical illness myopathy, respiratory failure, pneumonitis, severe sepsis, bacteremia, malignant neoplasm of brain, acute kidney failure, gastrostomy, heart failure, anemia, urinary tract infection, pleural effusion, pseudomonas, gastro-esophageal reflux disease, anxiety, type 2 diabetes mellitus, malignant neoplasm of thyroid, dysphagia, and atrial fibrillation.</p> <p>Record review of Resident #294's computer face sheet, dated 3/19/2025, did not indicate the resident's code status.</p> <p>Record review of Resident #294's care plan, dated 3/19/2025, revealed no indication the resident was DNR.</p> <p>Record review of Resident #294's Physician Order Report, dated 3/19/2025, revealed no physician's order for DNR status.</p> <p>In an interview on 03/19/2025 at approximately 1:50 PM with Resident #294 stated she was unaware if she has signed an advance directive recently but wants to be a DNR (Do Not Resuscitate).</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #295's electronic face sheet, dated 03/20/2025, revealed a [AGE] year old male who was admitted to the facility on [DATE]. Resident #295 had diagnoses which included; acute and chronic respiratory failure (lung failure), chronic obstructive pulmonary disease (lung disease that leads to difficulty breathing), Type 2 diabetes, tracheostomy (surgical airway), depression (a mental health condition including feelings of sadness, loss of interest and low energy levels), anxiety disorder (group of mental health conditions includes excessive and persistent fear or worry impacting daily life and functioning), schizoaffective disorder (combination of schizophrenia and a mood disorder), insomnia (sleep disorder), encephalopathy (brain disfunction or damage), myocardial infarction (heart attack), acute kidney failure, and morbid obesity.</p> <p>Record review of Resident #295's computer face sheet, dated 3/19/2025, did not indicate the resident's code status.</p> <p>Record review of Resident #295's care plan, dated 3/19/2025, revealed no indication of the resident's code status.</p> <p>Record review of Resident #295's Physician Order Report, dated 3/19/2025, revealed no physician's order for Code status.</p> <p>In an interview on 03/19/2025 at approximately 2:00 PM with Resident #295 stated he was unaware if he has signed anything like that or not and don't remember anyone asking but I want to be a full code.</p> <p>In an interview on 03/19/2025 at 1:25 PM, LVN B stated she was did not know the code status of Resident #294 or Resident #295 and was not sure how to find if Resident #294 or Resident #295 were a full code or DNR but she could find out.</p> <p>In an interview on 03/19/2025 at approximately 1:40 pm, the ADON stated all staff should know where to locate a resident's code status. The ADON stated LVN B would have to come out of the resident's room and ask for help to know if Resident #294 was a DNR or full code. She further stated, Resident #294 had been at the facility since 3/13/2025 with no advance directive orders but every new resident who was admitted in was a full code until further orders were obtained. She stated the staff would have performed life saving measures if Resident #294 were to code, since there was not a DNR order. She stated her expectation is for all staff to know their residents and their code status. She also stated, an adverse outcome would be a delay in care or place the resident at risk of having their end of life wishes dishonored.</p> <p>Record review of the facility's policy titled Advance Directives, dated September 2022, revealed [in part]:</p> <p>Policy Statement:</p> <p>The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy .</p> <p>Determining Existence of Advance Directive:</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.</p> <p>If the Resident Does not have an Advance Directive:</p> <p>Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732</p> <p>Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 3 of 12 Residents (Resident #8, Resident #5, and Resident #35) reviewed for assessments.</p> <p>The facility failed to ensure the MDS reflected the use of bed rails for Resident #8, Resident #5 and Resident #35.</p> <p>This deficient practice could place residents at risk of not receiving care for identified care needs.</p> <p>Findings include:</p> <p>1. Record review of Resident #8's electronic face sheet revealed a [AGE] year-old female who was readmitted to the facility on [DATE], original admitted [DATE]. Resident #8 had diagnoses which included respiratory failure, kidney failure and diabetes.</p> <p>Record review of Resident #8's Significant Change MDS, dated [DATE], revealed: BIMS of 15, which indicated no impaired cognition. Section P Restraints and Alarms revealed bed rails were not used.</p> <p>Record review of Resident #8's electronic Comprehensive Care plan, initiated on 12/26/24, revealed in part: Focus: Resident has an ADL self-care performance deficit. Goal: Resident will be clean, dry, and hygiene and dignity maintained. Interventions: SIDE RAILS: Half rails up as per doctor's order for safety during care provision, to assist with bed mobility and positioning. Observe for injury or entrapment related to side rail use. Reposition every 2 hours and as necessary to avoid injury.</p> <p>During an observation on 03/18/25 at 11:00 AM, Resident #8 was resting in bed with half side rails up on both sides of her bed.</p> <p>2. Record review of Resident #5's electronic face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included respiratory failure, heart failure and diabetes.</p> <p>Record review of Resident #5's Annual MDS, dated [DATE], revealed: BIMS of 12, which indicated no impaired cognition. Section P Restraints and Alarms revealed bed rails were not used.</p> <p>Record review of Resident #5's electronic Comprehensive Care plan initiated on 02/21/25, revealed no evidence of the use of side rails.</p> <p>During an observation on 03/18/25 at 11:05 AM revealed Resident #5 was resting in bed with half side rails up on both sides of her bed.</p> <p>3. Record review of Resident #35's electronic face sheet revealed a [AGE] year-old female who was readmitted to the facility on [DATE], original admitted [DATE]. Resident #35 had diagnoses which included fracture of arm, diabetes, anxiety, and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #35's Significant Change MDS, dated [DATE], revealed a BIMS score was not completed. Section P Restraints and Alarms revealed bed rails were not used.</p> <p>Record review of Resident #35's electronic Comprehensive Care plan, initiated on 02/14/25, revealed in part: Focus: Resident requires siderails while in bed. Goal: Resident will be safe and free from injury related to use of side rails and will have increased mobility and independence for turning and repositioning. Interventions . Instruct use of side rails & how to use them to promote independent repositioning of self, and Side rails up when in bed at all times for safety and support.</p> <p>Record review of Resident #35's Bedrail consent, signed 01/28/25, revealed: 1/2 partial rails to left up and right upper bed.</p> <p>During an observation on 03/19/25 at 10:26 AM, revealed Resident #35 was resting in bed with half side rails up on both sides of her bed.</p> <p>During an interview on 03/20/25 at 12:09 PM, the DON stated side rails should have been care planned and claimed on the MDS. She stated MDS's were completed by an outside MDS consultant at this time. She stated MDS consultant was responsible for ensuring the MDS was accurate.</p> <p>During an interview on 03/20/25 at 12:30 PM, the Administrator stated MDS's were completed by an outside MDS consultant. She stated the consultant worked remotely but attended the facility's daily morning meetings via phone call. The Administrator stated side rails should have been claimed on the MDS assessment. She stated she did not have contact information for the MDS consultant. She stated the facility did not have an MDS policy.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722</p> <p>Based on observation, interview and record review the facility failed to develop and implement a comprehensive person -centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 12 residents (Resident #5 and #26) reviewed for care plans.</p> <ol style="list-style-type: none"> The facility failed to ensure a care plan was developed to address Resident #5's use of bedrails. The facility failed to ensure a care plan was developed to address Resident #26's ostomy care. <p>These failures could place residents at risk for not receiving necessary care and services or having important care needs identified.</p> <p>Findings include:</p> <p>Resident #5</p> <p>Record review of Resident #5's electronic face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included respiratory failure, heart failure and diabetes.</p> <p>Record review of Resident #5's Annual MDS, dated [DATE], revealed a BIMS of 12, which indicated moderate cognitive impairment. Section P Restraints and Alarms revealed bed rails were not used.</p> <p>Record review of Resident #5's electronic Comprehensive Care plan, initiated on 02/21/25, revealed no evidence of the use of side rails.</p> <p>During an observation on 03/18/25 at 11:05 AM, Resident #5 was resting in bed with half side rails up on both sides of her bed.</p> <p>Resident #26</p> <p>Record review of Resident #26's electronic face sheet, dated 03/19/2025, revealed a [AGE] year-old female who was admitted initially to the facility on [DATE] with a readmission on 01/18/2025 with the following diagnoses: Chronic Obstructive Pulmonary Disease), congestive heart failure, Respiratory failure, High Blood Pressure, Type 2 diabetes.</p> <p>Record review of Resident #26's significant change MDS Assessment, dated 01/25/2025, revealed Section C - cognitive patterns: Resident #26's had a BIMS of 10 which indicated moderate cognitive impairment Section H-- Bladder and Bowel, revealed she had an ostomy.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #26's Care Plan, initiated 02/13/2025, revealed no evidence of ostomy care.</p> <p>Record review of Resident #26's Physician orders revealed no order for ostomy care prior to 03/19/2025.</p> <p>During an observation and interview on 03/18/2025 at 10:41 AM revealed Resident #6 had an ostomy bag. Resident #26's skin around the ostomy did not appear red and the site was clean. Resident #26 stated that staff assist Resident #26 with her care of her ostomy, she said her only complaint was that staff will not empty it when its only half full. Resident #26 stated she wanted her ostomy bag emptied every night before bedtime no matter how full it was, because she did not want it to bust while she was sleeping.</p> <p>During an interview on 03/20/2025 at 12:01 PM, the DON stated her expectation was ostomy care and bed rail use should have been included in the Resident's care plan. The DON stated the MDS nurse was responsible to complete the care plans and she was responsible to monitor. The MDS nurse did not work in the facility, it was an outside contracted source. The DON stated the effect on the resident for their care plans not being accurate could have caused the resident to have care needs not met. The DON stated she was responsible to monitor. The DON stated what led to failure was lack of monitoring by herself and the facility was transitioning from one electronic medical company to another electronic medical company.</p> <p>Record review of the facility's policy titled, Colostomy/Ileostomy Care, dated October 2010, revealed, The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. Review the resident's care plan to assess for any special needs of the resident.</p> <p>Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, revealed: The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and physical psychosocial well-being.</p> <p>45732</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44722</p> <p>Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services.</p> <p>The facility failed to ensure DA A performed hand hygiene while preparing resident food trays.</p> <p>This failure could place residents at risk for contamination and food borne illnesses.</p> <p>Findings include:</p> <p>During an observation and interview on 03/18/2025 at 11:50 AM, revealed DA-A opened the refrigerator with her gloves on and took a container of lettuce out. She then used her gloved hands to take the lettuce out of the container and placed it on a resident's plate. DA-A opened the refrigerator door with the same gloved hands and placed the container back in the refrigerator and grabbed another container of chopped tomatoes and opened the container and removed the chopped tomatoes to put on the same resident plate without changing gloves or washing hands. DA-A opened the refrigerator with the same gloves on and removed a bag of lettuce. She then removed the lettuce from the bag with the same gloves and placed it on the same resident's plate. DA-A then got an onion out of the refrigerator and placed it on the resident's plate without changing her gloves. DA-A stated she should have changed gloves and did not have a reason as to why she did not.</p> <p>During an interview on 03/20/2025 at 10:37 AM, the DM stated her expectation was for all staff to wash their hands with soap and water as well as change their gloves in between touching surfaces other than food. The DM stated when tasks are changed, you should change gloves. She stated the DA should not have used her glove hands to pick up the lettuce, tomatoes, and onions, and should have used a utensil instead. The DM stated all staff were trained as well as having their food handlers' certificate, so they should know what they were supposed to do. She stated DA-A was hired on 03/31/2023. The DM stated she was responsible for monitoring the staff to ensure staff followed policy regarding hand hygiene. The DM stated the effect on residents could have possibly been the spread of food born illnesses. The DM stated DA-A's laziness led to a failure of not having changed her gloves or using appropriate utensils.</p> <p>During an interview on 03/20/2025 at 1:10 PM, the ADMN stated her expectation was to follow the facility policy. She stated the DM was responsible to monitor staff and should have monitored accordingly. The ADMN stated the negative affect for residents could have been the spread of foodborne illnesses. She stated she did not really know what the failure was in why the staff had not washed her hands, but she could have been nervous or just not thinking.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, dated October 2017, revealed: Employees must wash their hands: .Before coming in contact with any food services .after handling soiled equipment or utensils; During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or After engaging in other activities that contaminate the hands .Gloves are considered single-use items and must be discarded after completing the task for which they are used.</p> <p>Record review of the Food and Drug Administration Food Code 2022 Annex 4. Management of Food Safety Practices - Achieving Active Managerial Control of Foodborne Illness Risk Factors Annex 4 - 7:</p> <p>Full Document accessed 03/20/2025 revealed:</p> <p>.practicing no bare hand contact with ready-to-eat food as well as proper handwashing, and implementing an employee health policy to restrict or exclude ill employees are important control measures for viruses.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722</p> <p>Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were that were complete and accurately documented for 1 of 12 (Resident # 6) residents reviewed for resident records.</p> <p>The facility failed to ensure Resident #6's physician orders contained orders for the care of Resident # 6's ostomy.</p> <p>This failure could place residents at risk of having errors in care and treatment.</p> <p>The Findings include:</p> <p>Record review of Resident #26's electronic face sheet, dated 03/19/2025, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] with a readmission on 01/18/2025. Resident #26 had diagnoses which included Chronic Obstructive Pulmonary Disease, congestive heart failure, Respiratory failure, Hight Blood Pressure, Type 2 diabetes.</p> <p>Record review of Resident #26's significant change MDS Assessment, dated 01/25/2025, revealed in Section C - cognitive patterns: Resident #26's had a BIMS of 10, which meant moderate cognitive impairment. Section H-- Bladder and Bowel, revealed she had an ostomy.</p> <p>Record review of Resident #26's Care Plan, initiated 02/13/2025, revealed no evidence of ostomy care.</p> <p>Record review of Resident #26's Physician orders revealed no order for ostomy care, prior to 03/19/2025.</p> <p>During an observation and interview on 03/18/2025 at 10:41 AM revealed Resident #26 had an ostomy bag. Resident #26's skin around the ostomy did not appear red and the site clean. Resident #26 stated staff helped her with emptying and changing her ostomy bag. Resident #26 stated her only complaint was that they will not always empty her ostomy bag at bedtime if it is not full, she stated she preferred for her ostomy emptied before bedtime no matter how full the ostomy bag was.</p> <p>During an interview on 03/20/2025 at 12:01 PM, the DON stated her expectation was orders for ostomy care should be included in the Resident's active orders. The DON stated the nurse who received the orders for ostomy should have added orders to the resident's record. The DON stated the effect on the resident for their orders not being accurate could have caused the resident to have care needs not met. The DON stated she was responsible to monitor. The DON stated what led to failure was lack of monitoring by herself and the facility was transitioning from one electronic medical company to another electronic medical company.</p> <p>(continued on next page)</p>		

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